OCCUPATIONAL THERAPY INTAKE FORM

Child's Name:______________________________ Nickname: _________________ DOB: ________________

School: ________________________Teacher: __________________Phone/Email: ________________________

Pediatrician: ____Phone: ______________________________

Referral Source: ____Phone: ______________________________

Reason for evaluation/treatment: ____

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Parent 1: ____Email: _______________________________

Contact: Day: __________________ Evening: ___________________ Cell: ____________________________

Parent 2: ____Email: _______________________________

Contact: Day: __________________ Evening: ___________________ Cell: ____________________________

Home Address(es): ____

Siblings: Please list name(s) and age(s). ____

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Please indicate other therapies/services that your child has received:

Type of Service	*Previous*	*Ongoing*	*Therapist Name/Contact Information/Dates of Service*
Speech Therapy	[]	[]	________________________________
Occupational Therapy	[]	[]	________________________________
Physical Therapy	[]	[]	________________________________
Vision Therapy	[]	[]	________________________________
Dietician	[]	[]	________________________________
Counseling	[]	[]	________________________________
Other	[]	[]	Describe: _______________________

Prenatal/Birth/Antenatal History

Duration of pregnancy (wks): ______ Delivery Method: ______________ Birth Weight: ________________

Describe any complications during pregnancy and/or delivery: _______________________________

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Describe any significant concerns during early childhood (e.g., feeding, sleep, recurrent infections)

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Development: Please indicate the age in months at which your child attained these skills, if known. Please also note if there has been a regression or loss of skills; if so, when.

Smiled	Rolled over	Sat alone
Crawled	Stood alone	Walked alone
Fed self with fingers	Used fork/spoon	Transitioned to cup
1st words; sentences	Toilet trained	Rode tricycle

Please list your child's preferred activities/toys. ______________________________

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Describe your child's behavior when interacting with peers. ______________________________

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Does your child display any pronounced responses to different sensory experiences (e.g., sensitivity to noise, fabric textures, bright lights, strong odors)? If so, please describe. ______________________________

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Illnesses/Health Status

Hospitalizations/Surgeries

1. Age ______________ Reason ______________________________

2. Age ______________ Reason ______________________________

Has your child ever been unconscious? If yes, please explain. ______________________________

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Has your child ever had a seizure? ______________ Frequency/duration: ______________

Please describe your child's overall health – including eating and sleeping habits – at the current time.

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Medications

Please list any medications that your child currently takes: (both prescription and OTC)

1. ______________________________ Reason ______________________________

2. ______________________________ Reason ______________________________

Other

Please list known allergies. ______________________________

Describe any assistive devices or other accommodations utilized at home or school. ______________

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Please include any additional information (e.g., medical issues, family considerations, preferred goals) that you would like to share. ______________________________

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Parent Signature: ______________________________ Date: ______________